Army Fact Sheet

Army Behavioral Health and Calendar Year 2007 Army Suicide Event Report

An analysis of deployment status among confirmed completed Army suicides in 2007 demonstrated the following:

Deployment Status	Percent of Suicides
Never deployed (home station)	26%
First time deployers (in theater)	24%
Two or more deployments (in theater)	7%
Post-deployment (home station)	43%

The U.S. population's demographically-adjusted suicide rate for 2005 (the latest data available) is 19.5 per 100,000 based on age-adjusted (17-62 years of age) data from the Centers for Disease Control and the Army's adjustment for gender ratio.

The Army Suicide Evaluation Report (ASER) is generated for every confirmed suicide event. Our deliberate death determination procedures result in a number of events being categorized as pending. Therefore, as of 1 March 2008, the Army had completed 109 ASERs, but today, the current number of confirmed completed suicides for 2007 is 115 with an additional two cases pending final determination.

On 11 February 2008, the Army G-1 and The Surgeon General hosted the initial Suicide Prevention General Officer Steering Committee (GOSC). The GOSC is a multi-disciplinary team from across the Army.

The focus of this effort is to target root causes that may lead to suicide and change the behavior of leaders and Soldiers to recognize, intervene, and refer those who exhibit risk factors associated with suicide.

The GOSC approved the following:

(1) the distribution of recognition and intervention training materials;

(2) the establishment a suicide prevention analysis and information sharing cell that has epidemiological consultation-like capabilities, and

(3) staffing the draft GOSC charter and expanded membership to include external agencies including Veterans Affairs, the Centers for Disease Control, and the National Institute of Mental Health.

In subsequent meetings, the GOSC reaffirmed the Army Suicide Prevention strategies and expanded them. They include:

(1) raising awareness and building intervention skills;

(2) providing an analysis and information sharing cell;

(3) improving
access to comprehensive care;

(4) reducing stigma associated with seeking behavioral health care; and

(5) improving life coping skills. GOSC members discussed the value of providing lessons learned to the field and the need to get leaders directly involved in the process.

The Army Chaplain Corps' "Strong Bonds" training program is expanding to reach more Soldiers and Family members to improve relationship-building skills intended to reduce failed

relationships for both married and single Soldiers. In addition, commanders are continuing to emphasize Battlemind Training, which is designed to build resiliency for Soldiers and Families.

Unit Ministry Teams and leaders continue to provide Suicide Awareness briefings for leaders and Soldiers throughout the deployment cycle. Additionally, Applied Suicide Intervention Skills Training is provided to key leaders to enhance intervention skills, identify risk factors and warning signs, and refer at-risk Soldiers to the appropriate agency for care.

The Army's Medical Command is recruiting and hiring additional behavioral health providers. They are also screening all Soldiers for possible mental health problems during Initial Entry Training and during the pre- and post-deployment phases.

One of the key goals of the GOSC is to share information across the enterprise to reduce risk that may lead to suicide and further emphasize those key policies and programs that improve the well-being of the force.

It is crucial for our Soldiers to recognize that seeking help during times of stress is a sign of strength, not weakness. Leadership involvement is key to create healthy environments where Soldiers are encouraged to seek help.

The Army has instituted numerous programs and resources to provide for Soldiers and families in need. For example:

The Deployment Cycle Support Process is an initiative to provide a tool for Active Army and Reserve Component Soldiers, their Family members and DA Civilians to synchronize services available to deal with the stress associated throughout the deployment cycle.

In March 2007, the Army Medical Department stood up the AMEDD Suicide Prevention Office, which is committed to translating the results of surveillance and intervention into prevention and treatment programs. It launched a web-site, http://www.behavioralhealth.army.mil/, which is intended to be a comprehensive venue for Soldiers and family members to get information on a variety of mental and behavioral health issues and resources available.

Installations and units continue to implement local intervention programs with the assistance of the Community Health Promotion Council, Suicide Prevention Task Force, or Suicide Prevention Coordinators

Soldiers and Family members in need have ready access to existing and new services; all they need to do is ask their chain of command, chaplain, leader, buddy, or person trained in Applied Suicide Intervention Skills Training (ASIST) or Question, Persuade, Refer (QPR) for help.

To decrease suicidal behavior, part of the strategies focus on training Soldiers, leaders and Family members to recognize signs of suicidal behavior, understand the risks of suicide, intervention strategies, and how to refer individuals for follow-on support and care. Others initiatives focus on: developing life-coping skills, encouraging help-seeking behavior and eliminating stigma of seeking mental health care, buddy aid, maintaining constant vigilance, integrating and synchronizing unit and community programs, and maintaining surveillance of suicidal behaviors through the Army Suicide Event Report.

Suicide awareness training includes recognizing the verbal and nonverbal signs and symptoms, identifies behavioral and situational predictors, and Army installation and community support systems that help individuals in times of distress.

The Army pioneered a mental-health awareness and education program called the BATTLEMIND Training System that helps to prepare active and Reserve-component Soldiers as well as their Families for the stressors of war, and also assists with the detection of possible mental health issues before and after deployment. It informs them about the common signs and symptoms they may experience when readjusting after a combat deployment.

In 2006, the Army incorporated into the Deployment Cycle Support program a new training program called "BATTLEMIND" training. It is a strengths-based approach that highlights the skills that helped Warriors survive in combat instead of focusing on the negative effects of combat.

The Army's efforts to address behavioral health continued in 2007 as we expanded BATTLEMIND training with modules for pre- deployment training and for spouses.
The goals of post-deployment Spouse BATTLEMIND training are to:

* identify common areas of deployment-related concern or conflict that military Spouses and Soldiers experience
* provide strategies to enhance your and your Family's resilience after deployment
* identify cues for when to seek help and available resources for yourself and your Family

The acronym "BATTLEMIND" identifies 10 combat skills that, if adapted, will facilitate the transition home. An example is the concept of how Soldiers who have high tactical and situational awareness in the operational environment may experience hypervigilence when they get home. The post-deployment BATTLEMIND training has been incorporated into the Army Deployment Cycle Support Program, and is being used at Department of Veterans' Affairs Vet Centers and other settings. The program's acronym addresses:

Bonds (Social Support)
Adding/Subtracting Family Roles
Taking Control
Talking it Out
Loyalty and Commitment
Emotional Balance
Mental Health and Readiness
Independence
Navigating the Army System
Denial of Self (Self-Sacrifice)

Plans for Future: The Suicide Prevention GOSC will take a critical look at policies, procedures, climate and, culture as they pertain to suicide prevention. We will also approach Suicide Prevention from the broader scheme of behavioral health; focus suicide prevention training to build upon previous behavioral health training, such as that for post traumatic stress disorder; stress efforts to reduce stigma and get help earlier; change the behavior of leaders and Soldiers to seek behavioral health care; and redouble leaders' efforts to prevent suicides.